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HOSPITALS FOR RURAL PEOPLE.

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MODERN ADVANCEMENTS IN MEDICAL SCIENCE HAVE PRECIPITATED THE NEED FOR ADEQUATE UP-TO-DATE HOSPITAL FACILITIES REASONABLY CLOSE TO ALL PEOPLE. RURAL COMMUNITIES HAVE UTILIZED FEDERAL AID, STATE AID, ASSISTANCE FROM FOUNDATIONS, CIVIC BONDS, AND VOLUNTEER CONTRIBUTIONS AND DRIVES TO ERECT AND EQUIP HOSPITALS. HOSPITAL CARE FOR RURAL PEOPLE USUALLY TAKES THE FORM OF GROUP INSURANCE THROUGH EMPLOYERS' OR FARMERS' ORGANIZATIONS. STEPS INDIVIDUALS CAN TAKE IF NEW HEALTH FACILITIES ARE NEEDED IN THEIR COMMUNITY INCLUDE--(1) INTEREST OTHERS, (2) DETERMINE NEEDS AND OBJECTIVES, (3) DEVELOP FINANCING PLANS, (4) ENLIST SUPPORT OF A SPONSORING GROUP, (5) GAIN HELP FROM PROFESSIONAL GROUPS, (6) INVESTIGATE HOSPITAL SERVICES PAYMENT PLANS, AND (7) DEVELOP EDUCATIONAL PROGRAMS TO PROMOTE HEALTH GOALS. THIS BOOKLET IS ALSO AVAILABLE FOR $0.15 FROM THE SUPERINTENDENT OF DOCUMENTS, GOVERNMENT PRINTING OFFICE, WASHINGTON, D.C. 20402. (SF)

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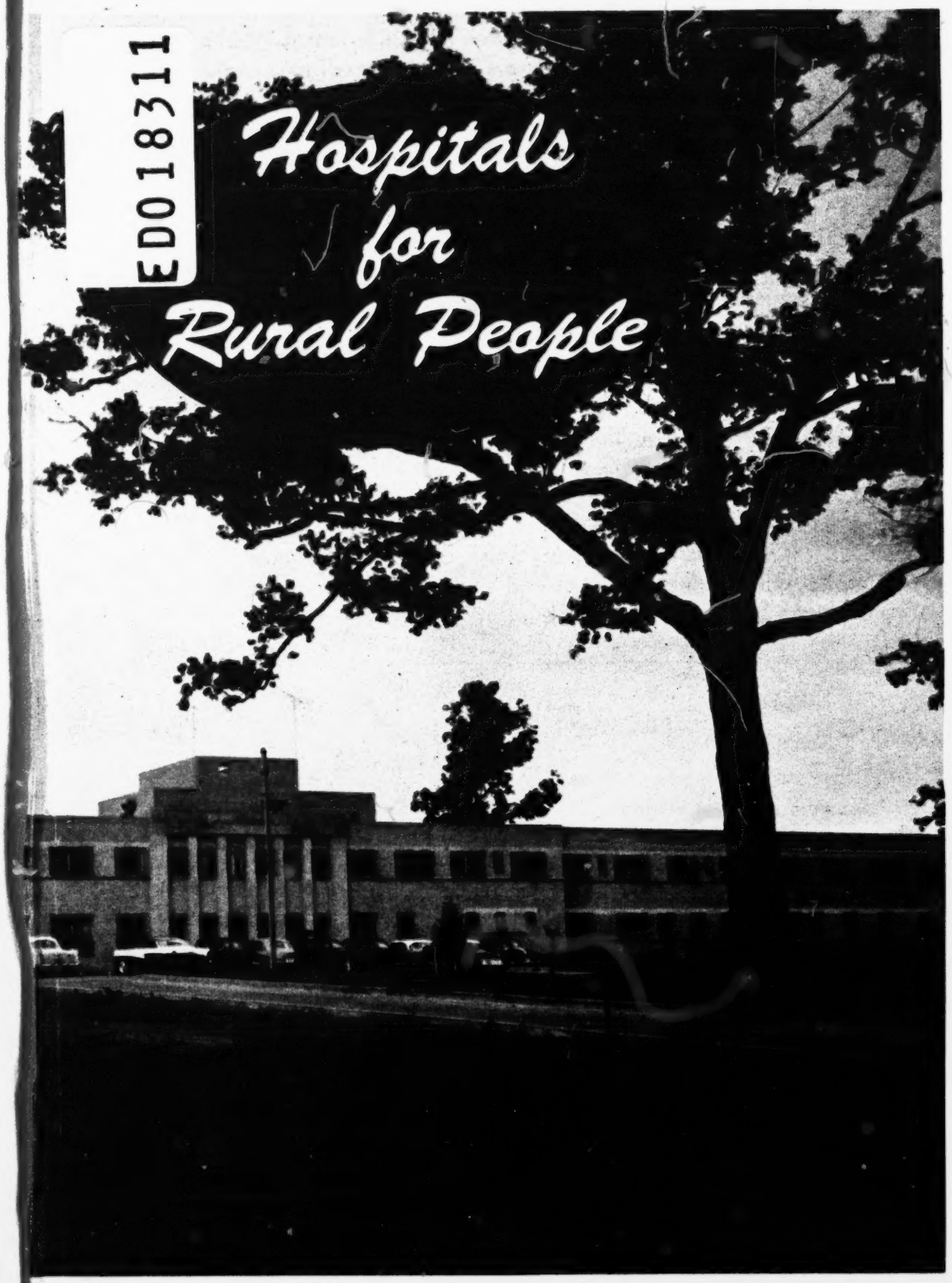
Hospitals for Rural People



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RC002420

Provision for maintenance of health is a cooperative enterprise involving many individuals and community groups. To assure that its health needs—both present and future—can be met, a community needs to appraise its local health services in relation to those in surrounding areas. Are effective methods available for the care and control of illness? Are all people within reach of facilities for the diagnosis and treatment of injury and disease? Are existing health facilities being used by all who live in the service area?

The Farm Population Branch, Economic Research Service, has done research and published reports in the field of rural health for many years. The Branch has made a number of surveys on rural health in cooperation with State agricultural experiment stations. A Farmers' Bulletin on rural hospitals was published in 1926. Another Farmers' Bulletin, ***Hospitals for Rural Communities,*** superseded it in 1937.

The purpose of this bulletin is to help acquaint rural people with recent nationwide progress in making health facilities available, and to broaden understanding of the possibilities for meeting needs in their own communities. It was prepared by the Economic Research Service, U.S. Department of Agriculture, with the cooperation and assistance of USDA's Federal Extension Service and the following units of the Department of Health, Education, and Welfare: Office of the Commissioner, Social Security Administration; Division of Hospital and Medical Facilities and Division of General Health Services, Public Health Service.

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Hospitals for Rural People

by Elsie S. Manny, *Social Scientist,* Economic Research Service and Charles E. Rogers, *Information Specialist,* Operations Management Staff

In earlier days, the doctor was seldom called unless somebody in the family was seriously ill. He came with his little black bag containing the tools and medicines known at the time. By horse and buggy or Model-T he made the rounds of bed patients in their homes. He transmitted his confidence and comfort to the sick and gave them the benefit of his medical knowledge and skill.

The modern doctor, though he may still make house calls if he is a general practitioner, has far better means to diagnose and alleviate illness. No longer does he carry with him all the tools of his trade. Present-day medical practice requires the use of the laboratory and X-ray equipment. With these modern instruments the doctor can conduct complete physical checkups of patients, and thereby detect and diagnose serious ailments and diseases. For treatment of many diseases, hospitalization is today essential.

Instead of spending the greater part of his time calling on patients, the modern physician sees most of them in his office, clinic, or hospital. The equipment he needs is there, and he can see many more patients in a day. Physicians now are trained in hospitals that provide modern facilities for prevention, diagnosis, and treatment of illness.

In many rural communities, primary medical equipment and services may be supplied through clinics that provide outpatient diagnostic and treatment services. There is need to develop relationships between such clinics and nearby hospitals if the health of the community is to be fully safeguarded.

An example of this relationship in medical services, operating since 1935, is the Bingham Associates program, which includes approximately 40 large and small hospitals in Maine and Massachusetts. The diagnostic, research, and teaching facilities of the New England Medical Center in Boston are made available to the general practitioner through regional and community hospitals affiliated with the program.

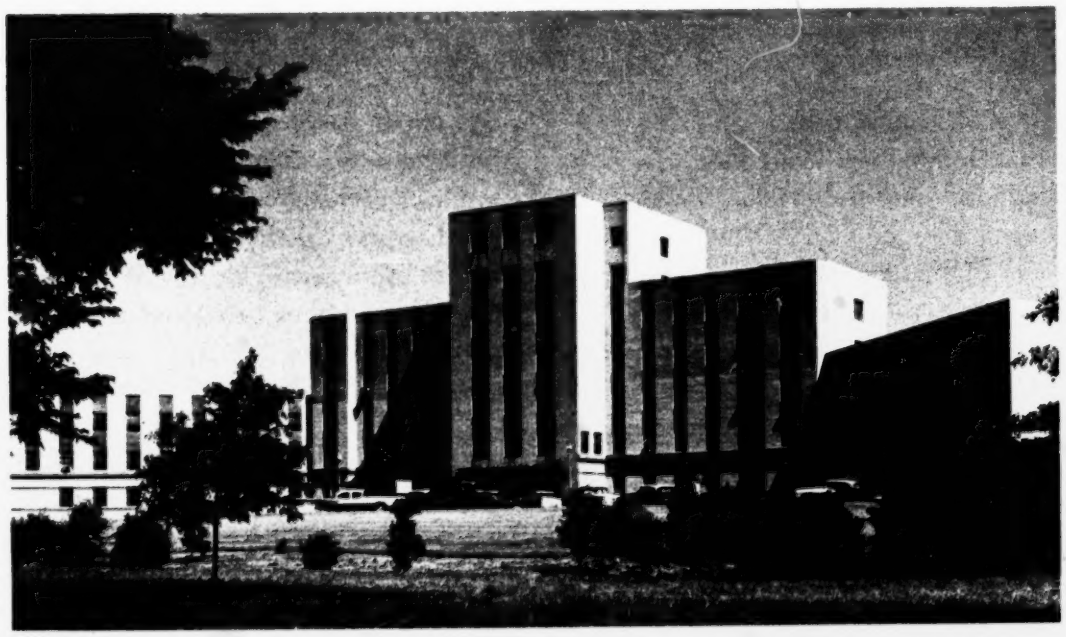
Hundreds of communities across the country have secured needed medical services. In others, a lack of health facilities stands in the way of obtaining adequate medical care. Communities in which doctors do not have access to modern facilities face increasing difficulty in attracting young physicians to replace older practitioners as they retire.

The prevalence of farm accidents is among the factors which point up the need for better facilities within reach of farm families. Annual deaths from farm accidents are estimated at about

65 per 100,000 of farm population. About a third of the farm population have nonfatal injuries annually. Only the mining and construction industries have a higher rate per person employed. Most frequently associated with accidents of farm people are motor vehicles off the farm, farm machinery on the farm, and falls in the home.

Chemicals used in fertilizers, insecticides, and weed killers are farm hazards. Some are poisonous by contact and by inhalation; and some are explosive. Safety precautions are necessary not only [illegible]se but in the storage of these chemicals. When using farm machinery some people disregard safety rules, and accidents resulting from negligence are common. It is estimated that 80 percent of farm accidents result from carelessness or failure to deal with hazards safely. When accidents happen, speedy availability of medical aid may mean the difference between life and death.

The advantages to mother and child when the baby is born in a hospital emphasize the importance of having such facilities accessible to rural people. A generation ago, only 37 percent of all babies in the United States were born in hospitals; in 1960, 97 percent were born in hospitals. For white babies, the percentage was 40 in 1935 and 99 in 1960; for nonwhite babies, the percentage was only 18 in 1935 and 85 in 1960—a higher percentage gain than for the white group.



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An example of a district or a regional hospital built with Hill-Burton funds is Charleston Memorial Hospital, Charleston, W. Va. This hospital has 274 beds. Its master plan calls for 440 beds. In operation since 1951, it provides for more complete and advanced diagnostic and treatment facilities than are normally possible in smaller hospitals. It has an outpatient department, and it houses a branch of the Charleston-Kanawha County Health Department.

HOW COMMUNITIES BUILD HOSPITALS

Services for farm families were greatly improved through Federal aid provided by Title VI of the Public Health Service Act of 1946—often referred to as the Hill-Burton program. This Act authorized Federal assistance to the States to provide "adequate hospital, clinic, and similar services to all their people." By June 30, 1963, 6,810 projects had received financial help or had been approved for assistance under the Act.

With the help of Hill-Burton funds hospitals were built in all 50 States, District of Columbia, Guam, Puerto Rico, and the Virgin Islands. Suwannee County Hospital—36 beds—in Live Oak, Fla., was the first built under the Act, in October 1948. Since then two additions have increased the size of the hospital to 66 beds. Remodeling and additions have been made to many other hospitals with the help of Hill-Burton funds.

To be eligible for Federal aid, a State is required to survey existing hospital facilities, outline hospital areas, and draw up a plan for meeting its needs. Within a State, priority of projects is based on relative need, "giving special consideration to hospitals serving rural communities and areas with relatively small financial resources." More than half of the new general hospitals assisted with Federal funds, are built in communities of less than 5,000 population, and fewer than a tenth in cities of 50,000 or over.

Continuous Statewide planning for additional health facilities has improved their distribution within each State. Standards for construction, maintenance, and operation required under this program have helped to raise the standards of other health facilities in the area.

In addition to hospitals, the Hill-Burton Act provides for assistance in building public health centers, many of which are located in rural areas. Specialists in large hospitals may supply part-time services to these centers.

Federal aid on approved projects varies from one-third to two-thirds of the cost of construction. A few States have augmented Federal funds with varying proportions of State aid to build hospitals and public health centers in areas of high relative need. Though many projects are approved for Federal aid, funds are not sufficient to help all cases in need of additional facilities.

Some communities finance their local units without Federal aid, but others, even when aid is offered, cannot raise the money necessary to meet building costs. In some cases, a community joins with neighboring towns or counties to support a hospital to serve a wide area. In the consideration of local health needs, increasing emphasis is being given to coordinated community-wide planning.

Additional uses of Federal funds are provided in the 1954 amendments to Title VI of the Public Health Service Act. Provision was made to help finance diagnostic and treatment centers, facilities for the care of patients with chronic illness and disabilities, and rehabilitation facilities. These amendments have stimulated the building of nursing homes, chronic disease wings of general hospitals, and other long-term care facilities.

This approach is in keeping with the emphasis on treatment of chronic dis-

ease and mental illness in community-based facilities or in wings of general hospitals, rather than in the traditional large institutions. Such treatment enables patients to maintain contacts with home and community even during long-term illness.

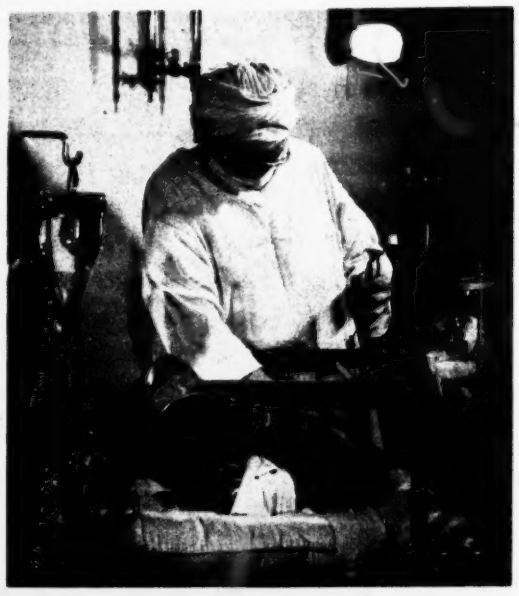
Statewide planning is essential in providing adequate facilities for the diagnosis and treatment of mental illness and the rehabilitation of the patients. The Act is stimulating progress in carrying out the latest treatment methods, but greater coordination of facilities is needed in many areas.

The enactment of the Community Health Services and Facilities Act of 1961 has expanded outside-the-hospital health services, particularly those for the chronically ill and the aged. Emphasis is on rehabilitation, restoration, and self-care. Projects include the coordination of community health facilities, the recruitment and training of personnel in long-term care of patients, home nursing programs, and homemaker services. Grants totaling 5.6 million dollars were awarded for 68 projects during the 1963 fiscal year. Thirty-four of these were concerned with home care for long-term and elderly patients.

The Act also increased from 10 to 20 million dollars the annual appropriation authorization for Federal grants to States for the construction of public and other nonprofit nursing homes under the Hill-Burton program.

The annual appropriation authorization for research was raised to 10 million dollars. Financial support is given to projects showing the greatest promise of contributing new knowledge with wide applicability.

Building a hospital requires community action. Often a community



A nurse trained in the care of the premature infant is shown feeding a baby in an incubator by means of a stomach tube. This is a Virginia State Department of Health photograph.

survey is made to find out if a hospital is needed. To receive Federal aid, plans for the hospital must be approved by the State agency responsible for administering the program. Local needs will be considered in relation to the areawide planning for health facilities. Projects are frequently sponsored by existing or newly formed hospital boards or associations.

A nationwide survey indicated that county or municipal governing bodies often sponsor the projects. (See *Community Health Action* by Paul A. Miller *et al.*, Michigan State College Press, East Lansing, 1953.) Sponsoring groups were appointed by local officials or selected through community-wide elections for the chief purpose of raising money for construction. Their success depended upon help given them by community organizations and groups.

METHODS OF RAISING FUNDS

More than half of the communities that build hospitals conduct local fund-raising campaigns, and almost half float county bond issues. Some communities use a combination of methods. Usually a fund-raising campaign is carried on intensively for a short period—1 to 3 months.

In addition to Federal aid received hospital projects very often are strongly supported by local people.

Fourth of July auctions raised $57,000 for the construction of the 44-bed Hardin Memorial Hospital in Kenton, Ohio. A bond issue as well as Federal aid was needed to complete the hospital. Auctions continued to help pay for new equipment. See picture, page 6.

Cooperative efforts of local, State, and Federal agencies made possible the building of the Minnie G. Boswell Memorial Hospital—28 beds—at Greensboro, Ga. Two additions, providing 23 more beds, were built also with the help of Hill-Burton funds.

The Health and Welfare Committee of Latimer County, Okla., solicited funds and the county voted bonds for a combination 20-bed hospital and public health center. Federal funds covered $144,000 of the total $296,000 estimated cost.

In Perryville, Mo., population 5,000, it took three bond issues plus Federal aid and local contributions to build the 55-bed Perry County Memorial Hospital. A group of women known as "hospital volunteers" sewed thousands of items and served as receptionists in the hospital.

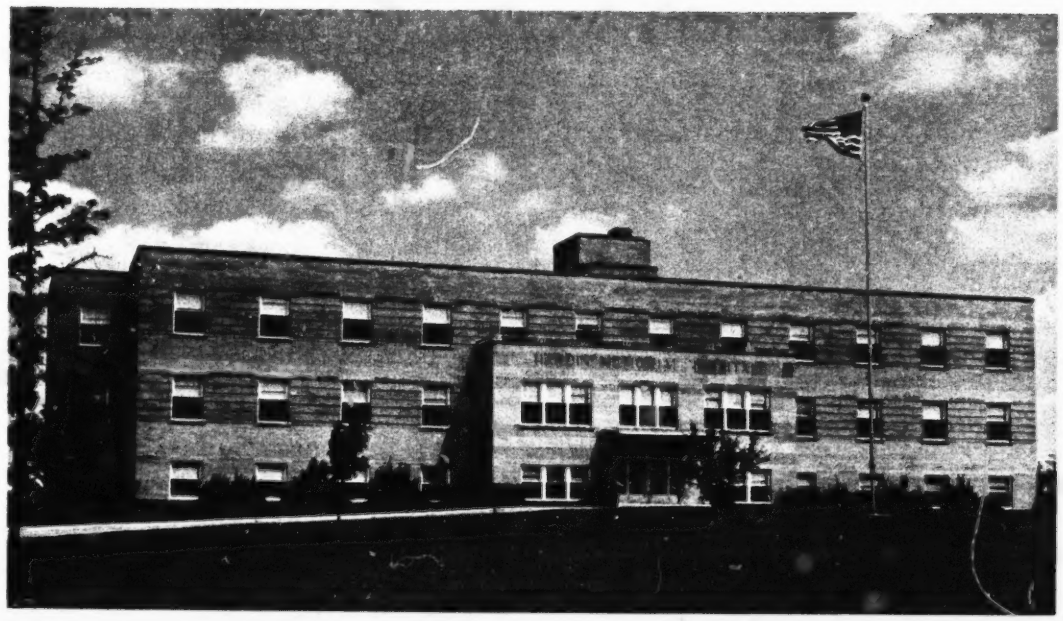
The Santa Fe County Health Department, N. Mex., has a new building with modern equipment and facilities. This building and its facilities were made possible through county funds and Federal aid.

Formation of an active Health Council resulted in putting the drive for hospital funds over the top in Taylorsville, Alexander County, N.C. A combination 20-bed hospital and health center is kept operating through volunteer work and contributions.

Residents of Raleigh County, W. Va., approved a special levy which, with Federal aid, made possible the construction of a $200,000 health center serving parts of Fayette, Raleigh, and Summers Counties.

Many communities build hospitals without Federal aid. In some instances assistance is not requested; in others aid is not available because the area does not have a high priority rating for the allocation of funds. An individual or group, convinced of the need, promotes the idea until it is supported by the community, and the hospital becomes a reality through community action.

Frequently, several financial campaigns are necessary before construction can be started. Local volunteers solicit pledges from individuals and organizations in the hospital service area. Often, gifts are received from friends and former residents of the area. Meanwhile the leaders of the campaign may obtain help from the county through a bond issue, tax levy,



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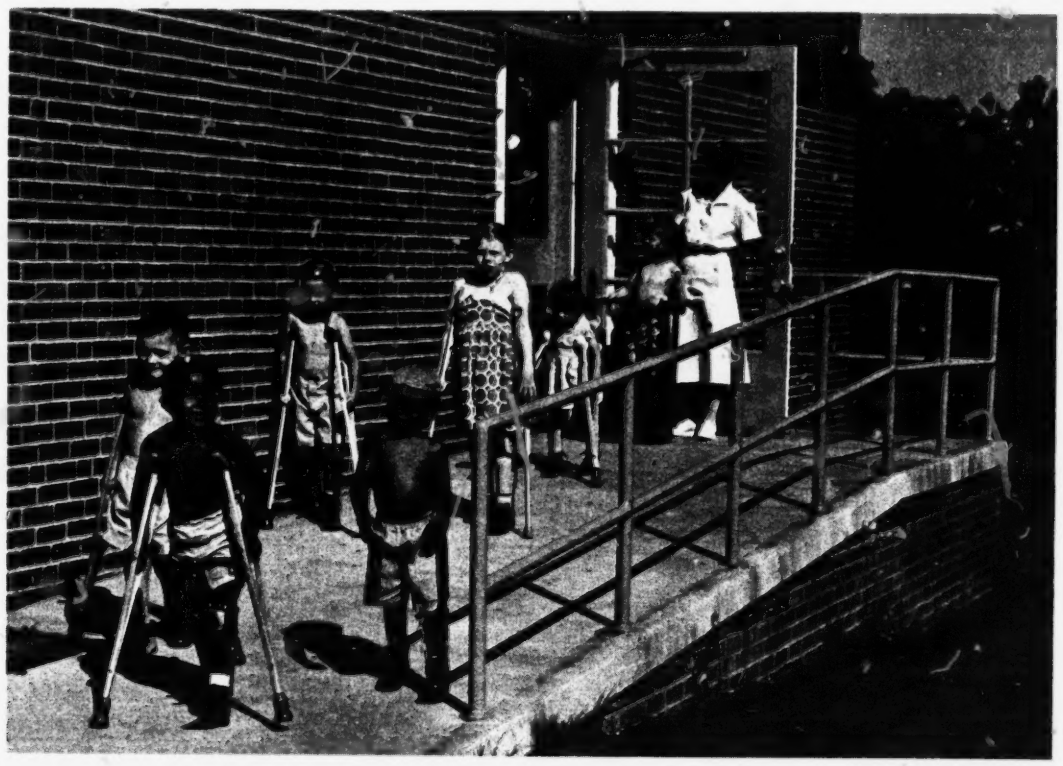
Hardin Memorial Hospital, Kenton, Ohio, was built with Federal aid amounting to $154,689. Local people raised the rest of the $509,068 needed for construction.



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This 40-bed Cerebral Palsy Hospital at Durham, N.C., was built with Federal aid.

or grant. Health cooperatives or hospital associations assist in organizing and subsidizing construction and operation of the hospital. Donations of labor and equipment, as well as contributions of time and talent, often result in substantial savings in the costs of local projects.

The following are typical examples of community effort to obtain and operate hospitals without Federal aid; the list could be extended to include hundreds of others.

Volunteer labor helped to make possible a 32-bed hospital in Tigerton, Shawano County, Wis. A health cooperative with a membership fee of $100 gives part ownership and the opportunity to use the service plan. The plan covers office calls and treatments as well as hospitalization and other benefits.

The Gothenberg Memorial Hospital—26 beds—in Dawson County, Nebr., was built and equipped in 1949–50 for only $70,000 because local people contributed labor as well as money raised through auction sales, dinners, and other public events.

Under the leadership of a young doctor, the farmers around Hopedale, Ill., built a 20-bed well-equipped hospital and later a nurse's home and a 40-bed convalescent wing to the hospital. These were financed by bond issues and donations of money, work, and material.

Citizens of Salina, Utah, population 1,700, built a 12-bed hospital which attracted a doctor to their community.

Contributions and a bond issue raised $250,000 within two years to build and fully equip a 26-bed hospital in Belmond, Iowa, which draws patients from four counties.

Local labor and the use of Army surplus material reduced the cost of a modern 38-bed hospital in Siloam Springs, Benton County, Ark. Additional funds were raised through a bond issue, farm sales, and numerous other money-raising plans.

Donations of labor, equipment, and materials by local people made the hospital at Faith, S. Dak., a reality.

For each 50 hours of service given to the Madison Valley Hospital—5 beds—in Ennis, Mont., volunteers are credited with a free day of hospital care for themselves or their families. Local people built the hospital, and a young doctor brought in the first equipment.

Built through aid from the Commonwealth Fund, the Beloit Community Hospital, Mitchell County, Kans., is kept operating through volunteer support in addition to patients' fees. The Economy Shop, which sells donated clothing, jewelry, shoes, and other articles, contributes its profits for new equipment. A banquet, featuring outside speakers, inaugurates the annual financial drive. Interest from an endowment fund, established in 1950, also is used to meet operating expenses.

The "Ten-Acre Wheat Club"—each farmer giving the money made on 10 acres of wheat—helped to raise $200,000 for Kit Carson Memorial Hospital—32 beds—in Burlington, Colo. A 17-man board of local people was set up to formulate plans for erection of a new hospital. When closing his private hospital, a doctor donated the equipment to the new one. Home demonstration clubs

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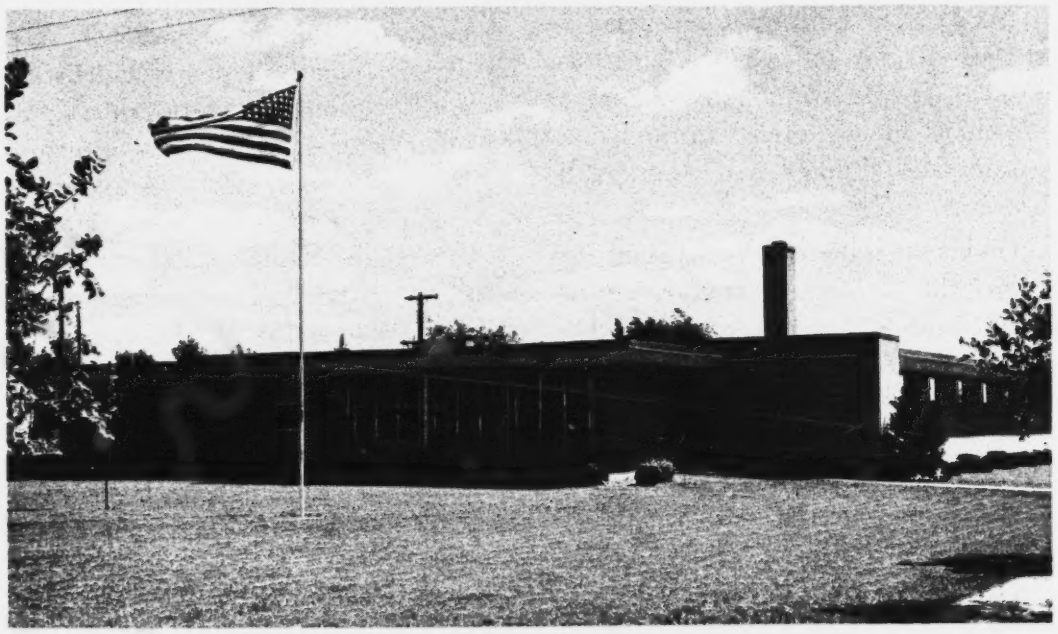
made draperies and raised money for painting and furnishing rooms.

Women in the hospital auxiliary pay a dollar a year in cash and give as many hours of work as possible. Garden clubs undertook a long-time landscaping plan. Although some help toward maintenance is provided by a small tax levy, farmers, townspeople, and civic and other organizations continue to contribute toward the operation of their hospital just as they did toward its construction.

Two communities joined forces to build the Trimont Community Hospital—16 beds—at Trimont, Martin County, Minn., pictured below. A survey of potential patients showed that 5,000 or 6,000 people would be closer to Trimont than to any other town with a hospital. Following a mass meeting, a planning committee of 12 was appointed to estimate cost of construction and plan the fund-raising campaign.

Later, a 9-member board of trustees was elected, and plans were made to incorporate the hospital. Methods used in collecting $120,000 included the "500 Club" (each member pledging $500), benefit ball games, shows, dances, bake sales, and bequests or memorial gifts.

To pay for $30,000 worth of modern equipment, a 20-year trustee fund mortgage was drawn up at 4 percent interest. An 8-bed addition was built in 1958 at an approximate cost of $85,000. The hospital is debtfree and is well patronized by the village and surrounding farm community.



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This 16-bed hospital in Trimont, Martin County, Minn., was built without Federal aid. Local people, convinced of the need for a hospital, raised the entire amount necessary for construction and operation.

HOW COMMUNITIES FINANCE HOSPITAL CARE

With maintenance costs increasing each year, financing of hospitals has become a major problem. Building the hospital is just the first step. The average cost per patient per day to all short-term general and special hospitals in the country rose from $9.39 in 1946 to $34.98 in 1961, an increase of 273 percent. The total expense per patient stay increased by 213 percent from $86 in 1946 to $267 in 1961 even though the average length of stay decreased by 16 percent during this period.

Salaries paid additional personnel trained in the new procedures, techniques, and services, required as medical science advances, accounted for part of the increase. The number of full-time employees per 100 patients in these hospitals was 59 percent greater in 1961 than in 1946; annual compensation per employee increased 173 percent. In 1961, payroll expense in short-term hospitals accounted for 62 percent of the total expense of hospital operation.

About 75 percent of the work in an average hospital is done by women. Before industrial employment competed for women's services, hospitals benefited by the prevailing low wage scale. Because industrial employment now competes for women's services, hospitals have had to raise their entire wage scale to bring it more in line with industry.

The problem of providing hospital care is a continuing one. Many institutions are dependent upon local annual drives for part of their financial support. They receive financial aid from endowments, churches, fraternal organizations, welfare agencies, workmen's compensation funds, grants from United Givers Funds, and other agencies and groups.

Some county, State, and Federal hospitals are supported entirely by taxation. Some of these hospitals provide care only for patients with specific illnesses, such as tuberculosis or mental disease. Others provide care for all types of illness.

The chief source of revenue for most general hospitals is payments made by patients at the time of receiving care. For a large proportion of our population, the former method of paying for hospital services out of cash resources has been supplanted by payment through hospitalization insurance with organizations such as Blue Cross and other insurance companies.

HOSPITALIZATION INSURANCE

There are two kinds of hospitalization plans—those that pay the hospital directly when a member of a plan has been hospitalized, and those that reimburse the insured patient for part or all of the hospital bill, which he has already paid. The former are referred to as "service benefit plans;" they include Blue Cross plans and any other arrangements under which a third party (the insuring organization) pays the hospital bill of members. Plans that reimburse the insured rather than the hospital are called "cash indemnity plans." In general, service benefit plans provide a greater return per premium dollar.

A second distinction among plans relates to the extent to which a plan guarantees to pay all costs incurred in the hospital. Many Blue Cross plans agree to pay the cost of a semiprivate

room and all or part of the charges for operating room, routine laboratory procedures, drugs and medicines, anaesthesia, dressings and casts, and so on. Other plans provide a fixed payment for each day spent in the hospital, and a fixed maximum toward other hospital charges, whether or not these allowances are sufficient to meet the actual costs incurred. Plans vary as to the number of days of hospital care they provide as benefits—30, 70, or 120 days are most usual.

METHODS OF ENROLLMENT

Most enrollments in hospitalization insurance plans are through groups, either at an individual's place of work or through an organization such as the Grange, Farm Bureau, Farmers Union, cooperative creamery, or the like. Premiums are lower for the same benefits for a group because of economies in collecting premiums, and because a group is likely to be a cross section of good and bad risks.

Individuals and individual families, however, may purchase insurance from many companies and most Blue Cross plans. The latter often open their enrollment for brief periods to individuals who generally must be under 65 years of age. In addition, many insurance companies offer health insurance plans for persons 65 years of age and over with enrollment for a limited period. Almost all Blue Cross plans conduct annual enrollment campaigns on a community basis.

A successful enrollment campaign was conducted in Haywood County, N.C. The Haywood Community Development program sponsored a campaign in 1951. In order to qualify, it was necessary to sign up 75 percent of all families in the community. Hospital Care Association of Durham, N.C., was the underwriter with a Blue Cross plan for hospitalization which provided coverage for surgical care and for other in-hospital medical expenses. Through the local community hospital center the Mississippi Hospital and Medical Service has conducted programs of community enrollment in many counties.

THE ROLE OF PREPAYMENT IN FINANCING MEDICAL CARE

In 1959, 72 percent of the urban population and about 61 percent of the rural population had hospital insurance. Insurance met about two-thirds of the total private expenditures for hospital care in 1961 but less than a third of the costs for physicians' services.

Individuals who do not work for a large organization, persons over 65 years of age, nonwhites, and those with relatively low incomes are less likely than others to be insured. In rural areas which have a large proportion of self-employed people with incomes subject to year-to-year fluctuation, enrollment is relatively low.

However, the proportion of rural people having hospital insurance is increasing. Studies made in selected counties in New York State showed a significant increase in hospitalization insurance coverage among rural households between 1950 and 1958. Some people who do not qualify for group

enrollment may obtain adequate individual policies from other sources.

A hospitalized illness involves many kinds of expenses including the charges of surgeons and physicians. There is widespread concern with the problems hospital patients have in paying for necessary medical care. As the yearly increase in the number of people having coverage for surgical and medical expense shows, many people attempt to protect themselves against the costs of medical care.

A number of rural communities have provided a solution to the problem through health cooperatives which provide both hospital care and medical care. The oldest rural cooperative hospital is at Elk City, Okla. Established in 1929, it is operated by the Farmers Union Hospital Association. It provides not only hospital care and physicians' and surgeons' services to its members but out-patient care, including preventive medical services. Dental care is also provided.

Other rural health cooperatives have been formed in Texas and the Southwestern States. Benefits vary, but home and office care as well as hospital care is provided.

In planning a health program to meet the needs of a community, it is important to consider the value of health insurance for medical care and preventive and diagnostic services. Where comprehensive insurance arrangements have not been developed Blue Shield plans provide surgical and in-hospital medical expense insurance. Cash indemnity plans also are available to rural families as protection against surgical and hospital expenses.

Plans sponsored by medical associations in a number of States (for instance, California, Idaho, Oregon, and Washington) cover home and office visits of physicians as well as hospitalized illness. Other group plans on the West Coast include the Kaiser Foundation Health Plan, which provides comprehensive health care through its own system of hospitals and clinics. On the east coast, the Health Insurance Plan of Greater New York has extended its coverage to rural Columbia County, through the Rip Van Winkle Clinic in Hudson, New York.

As the Hospital Survey and Construction Act surveys have demonstrated, health facilities are not as readily available to rural as to urban population. And, as would be expected, people with relatively low incomes are less likely to receive health services than those with high incomes. If more low-income families were insured, benefits of modern medicine would become more widely available.

Public Law 86–778 (the Kerr-Mills Act) which went into effect on October 1, 1960, increased Federal grants to States to help in financing medical care of persons on old-age assistance and persons aged 65 and over who are not recipients of old-age assistance but whose income and resources are determined by the States to be insufficient to meet such costs. By December 1962, 25 States, Guam, Puerto Rico, and the Virgin Islands had taken advantage of this aid.

OTHER COMMUNITY HEALTH RESOURCES

PUBLIC HEALTH CENTERS

More than 1,900 public health centers have been built with Federal aid or approved for construction through the Hill-Burton program. Although the trend has been toward the organization of public health units on a district rather than on a single-county basis, the single-county organization continues to be the more prevalent type. In 1960, 79 percent of all counties, which included approximately 94 percent of the total population of the United States, were organized for full-time local public health services.

However, growth in full-time staffs of local health units has been slight. Because of the rapid increase in population, augmentation of staff has not been great enough to raise the ratios of public health workers to the population served. Rather, the national staffing situation reflects a downward trend in these ratios—the ratio of full-time public health workers employed by local health units in 1960 was 26.3 per 100,000 population, compared with 31.3 in 1950.

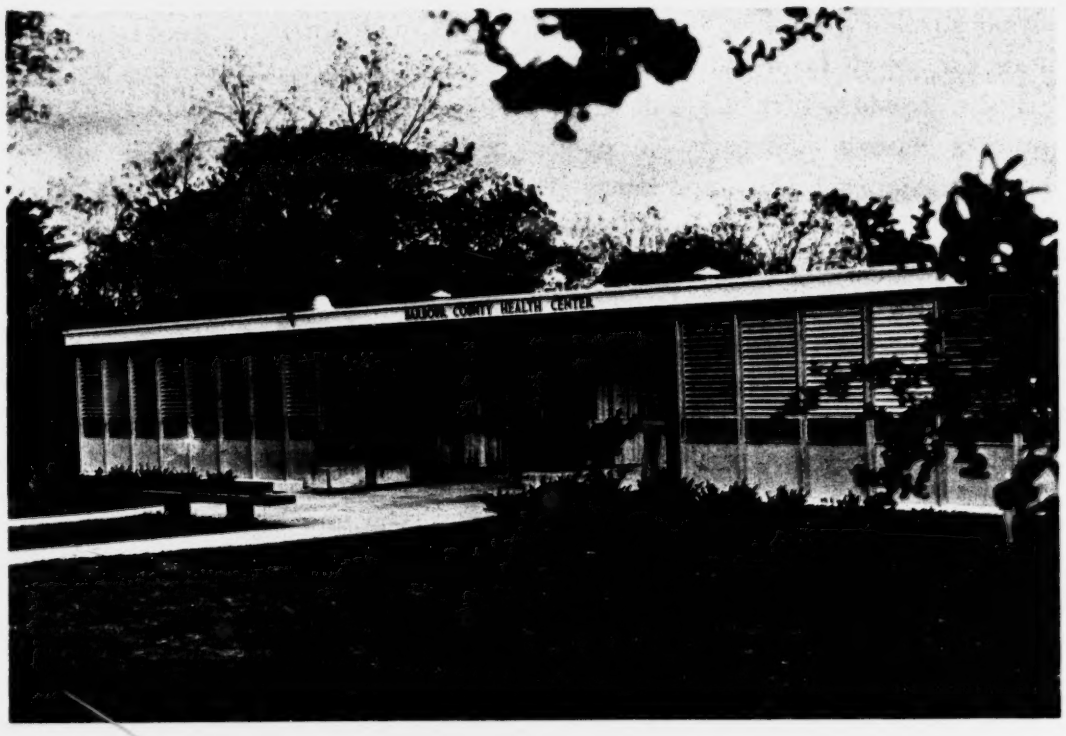
Public health services must compete with other needs, such as schools and highways, for public support. Many communities, however, find that a public health center contributes greatly to such preventive measures as prenatal care, well-baby clinics, immunization programs, laboratory tests, and community sanitation. Needless disability or early death from heart disease, cancer, and other dreaded illnesses may be prevented by early diagnosis and treatment.

The formation of health districts consisting of several counties, or a city and its surrounding county, is being used in some places as a means of providing more complete local public health services. Cooperation between counties in securing public health services is found in North Dakota and other States in the northern Great Plains.

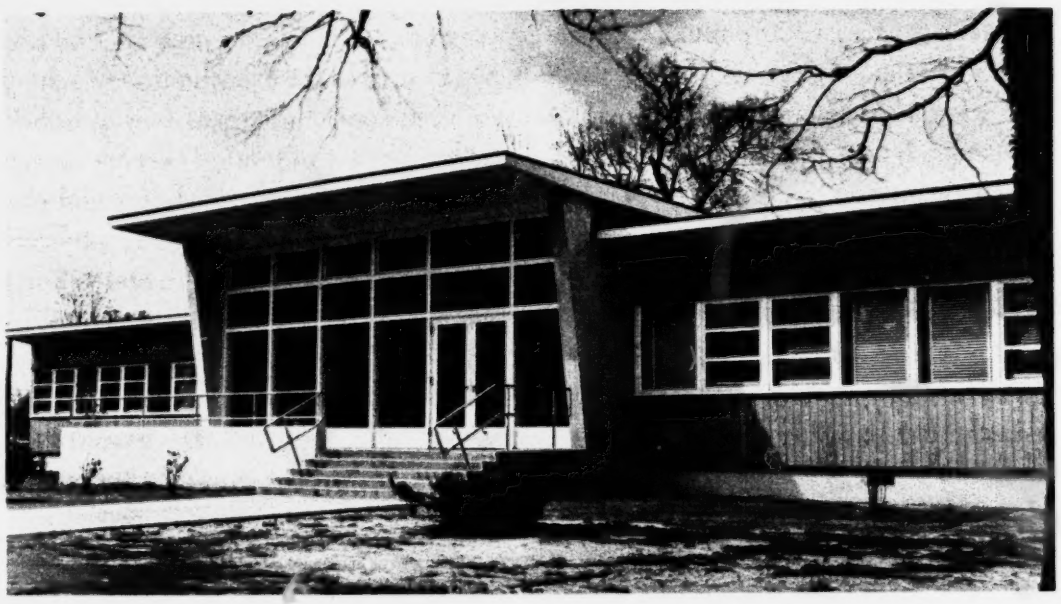
The work of public health personnel is being extended through the use of other community resources. Coordination of the health work of official and voluntary agencies is of increasing importance. The public health physician may also be a community leader who works with local organizations to help solve current health problems.

Examples are: (1) A community in Avoyelles Parish, La., approved a bond issue to put in a sewage system and improve its water supply after a local health committee publicized the need; (2) a volunteer health committee in rural Vermont stimulated the improvement of public health practices; (3) health surveys conducted by local people in many areas such as Crawford County, Ind., and Lincoln County, Nev., have revealed the need for additional health facilities and services; (4) a 3-year project conducted by Berea College, Berea, Ky., showed that rural schools are a medium for teaching health practices that spread into the homes and community.

An example of cooperation between home demonstration clubs and the county health department is the experience of Edgecombe County, N.C., where five communities worked together in building and equipping a public health clinic served by county public health personnel. The health leaders of local clubs help with the home



Barbour County Health Center, Clayton, Ala., is similar to hundreds of centers built in the South with the help of Federal funds. Total cost of this center was $88,630; the Federal share was $59,006. U.S. Public Health Service photograph.



This wing of a 52-bed hospital houses the outpatient department of the Crossett Health Center in the lumber town of Crossett, Ark. It serves the rural people within a 50-mile radius. Total cost was $748,581; the Federal share was $246,542. U.S. Public Health Service photograph.

demonstration programs, supply materials for the study of nutrition in the schools, conduct first aid and home nursing courses, and carry on other health activities. The importance of proper nutrition, housing, sanitation, and immunization in relation to health is emphasized. Area families are adopting preventive measures to improve and safeguard health.

In Franklin County, Ala., home demonstration clubs helped distribute brochures on health problems to 800 families and held discussions of health problems at each club meeting.

CLINICS

Very often clinics are built to attract a doctor to an area. In Kansas and Virginia, for example, the State medical schools cooperate with local communities in obtaining physicians.

The Pennsylvania State Medical Society helped the small community of Hookstown, Pa., (300 population) obtain a doctor. Proceeds from a town fair were used toward the purchase of a 9-room house for home and clinic, which attracted a young physician. The house was turned over to him for a year, rent free, with the option to buy or rent.

The Junior Woman's Club in Payson, Ariz., worked with other local people to make a $31,000 clinic a reality and to obtain a young doctor to take charge of the clinic.

The clinic at Mankato, the county seat of Jewell County, Kans., is shown on page 15. Built according to the chosen doctor's plan, the clinic consists of a large reception room, office for receptionist-secretary, doctor's consultation room, three treatment rooms, and a utility room which contains the heating system, X-ray and dark room, and storage for laboratory supplies. The clinic also has a well-equipped ambulance. Arrangements were made for the doctor to buy the clinic, and donations of time and material reduced the cost of construction.

Frequently, clinics are built with a few beds for emergency and obstetrical cases. For example, in Hanover, Washington County, Kans., a $30,000 health center was built, including offices for doctor and dentist, plus six hospital beds and four bassinets.

Clinics built by several doctors practicing as a group are becoming more common in rural as well as in urban areas. A doctor and his two sons built a clinic in Waverly, Lafayette County, Mo., which serves people within a 50-mile radius.

Mobile clinics are used in some areas to take services to rural people. For example, Delaware uses a mobile X–ray unit in the examination of school children for tuberculosis and a mobile cancer unit; the latter serves as an extension of the cancer clinics and emphasizes the value of regular physical examinations. Mobile dental clinics operate in several Tennessee and Virginia counties.

West Virginia operates two mobile X–ray units with efforts concentrated on migrant workers. Migrant health legislation in 1962 authorized grants to community organizations to pay part of the cost of family health service clinics and other projects to improve health conditions and services for domestic migratory farm workers and their families.

N 18750

Mankato Clinic, located in north-central Kansas, is typical of many clinics built to provide doctors with needed equipment.

TOWARD BETTER HEALTH

People's response to appeals for improved health services are widely varied. Some people are influenced by such intangibles as folklore, tradition, and deeply imbedded beliefs. More tangible influences are such considerations as distance from medical facilities, the age of people who have need of health services, whether they are men or women, and their income.

Local customs and standards of health often have a bearing. And to some people suggestions for improving the health of the community will mean more than plans for bettering their own personal health. In practice, programs promoted on a community basis often encourage residents to carry out improved health practices in their own homes.

COMMUNITY HEALTH PROGRAMS

Community development programs sometimes include activities to improve the health and safety of all families who live in an area. These have been strongly emphasized in the South. In such community endeavor, business groups and farmers' organizations take the lead in sponsoring contests and offering prizes to the community that makes the most improvements during the year. Civic clubs, farm agencies, public officials, institutions, and individuals work together to achieve goals.

Rural Areas Development Committees usually have a subcommittee on health that promotes improvements in community health services and facilities. Community projects related to

health include promoting safety in the home and on the farm, making improvements in sanitation facilities, sponsoring tests to detect cancer and tuberculosis, and building clinics.

Indirectly related to the health of the community are programs to improve schools, churches, community playgrounds, roads, telephone service, and agricultural products. Establishment of better rural-urban relationships may be a byproduct of these programs.

SPONSORING OF DIFFERENT TYPES OF FACILITIES

Experience shows that women's groups are generally most active in campaigns for public health centers; men's civic groups are most active in hospital drives.

To get people to see the importance of the preventive work of a public health center requires educational work. Some shy away from "public health," not realizing how important these programs are for the well-being of their families. There has been some tendency toward providing joint housing for hospital and public health services. This may help to associate the preventive and curative aspects of medicine.

Obtaining a hospital is a financial venture in which businessmen may be best prepared to take the lead, but assured success requires the support of all groups. A hospital is easier to dramatize than a public health center or a clinic. But the financial outlay for a hospital is vastly greater. After a survey of the health facilities of the entire area a community may decide that a clinic or public health center will meet its needs.

HOW WILL IT BE FINANCED?

In deciding on any project for new facilities—whether hospital or public health center—it is important to consider whether funds will be available to pay salaries of personnel and to meet operating and maintenance expenses, as well as to defray the first cost of building and equipment.

Communities raise funds in different ways, depending upon locality and resources. Bond issues, taxes, association dues, annual financial drives, voluntary gifts from individuals, institutions, groups, and organizations, as as well as to defray the first cost of methods that are used.

Raising enough funds often requires several campaigns in which different methods are used. Hospital service areas on the Pacific coast frequently incorporate into a hospital district for the purpose of issuing bonds to build and maintain a hospital.

Professional fund raising agencies are costly, but usually the financial goal is reached more quickly when they are employed than when only volunteer leaders are used. Case histories indicate that when local people take full responsibility for the campaign, they have a keener interest in the project and are more likely to support the hospital after it is built.

Upon completion, most hospitals are owned either by a nonprofit association, newly formed or already existing, or by a county or city government.

COMMUNICATION MEDIA

A sponsoring group tries to represent all sections of a service area and keep in touch with them during a campaign. Appeals arouse and encourage

active participation through newspaper articles, street corner discussions, speeches, handbills, posters, and radio and TV programs. Local leaders often call in technical assistance from professional agencies, particularly to help select the site, to develop blueprints, and to assist with problems of construction and of requirements of ownership and administration.

FAMILY DOCTOR AND SPECIALIST

In spite of increased specialization in medicine, the general practitioner is a vital link in the chain of health services. When several doctors set up practice together in a clinic, the personal relationship of the physicians with their patients may be maintained together with opportunity to perform specialized services. Doctors in group practice sometimes work out insurance plans for medical care.

One means of coordinating medical care is achieved by having the services of specialists available from city hospitals, on a part-time basis, in public health centers, clinics, and small hospitals in rural areas.

OPPORTUNITIES FOR LOCAL INDIVIDUALS AND GROUPS

Improvement of local health involves cooperation between individuals and groups supplying health services and the people who need them. Farm families can help bridge the gap between medical resources and their use. Even one individual or family can give the impetus necessary to enlighten a community to its needs. It often opens the way to opportunities available for obtaining better health through better use of existing services or through their expansion.

People do overcome difficulties and discouragement, and then work on to the fulfillment of their dreams of better health facilities, as thousands of community hospitals and public health centers testify.

But what can an individual do if new health facilities are needed in his community?

1. The first step, of course, is to interest other individuals and agencies concerned. These may be a local doctor, a health council, county or State health officers, county or State medical associations, or State health specialists, or a community organization in which health is a special concern.

State and county extension services frequently can be helpful in supplying data and in organizing a group to study the facts and make plans for a project. Meeting together, the group decides on an objective and coordinates efforts for attaining it.

A representative from the State Board of Health or State Hospital Construction Agency who is familiar with the State survey for the Hill-Burton program should be invited to outline the overall plan for health facilities. The plan will help the community to fit its program into the State picture. Other communities may be interested in joining the project. Discussion may bring out the fact that adequate facilities are already available and not fully used. An educational program may be what is needed.

County or community self-surveys are often helpful in providing basic facts about needs for facilities, health education programs, or other health projects.

2. The objective will be determined by conditions within your own com-

munity or county and neighboring areas. Both present and future local needs for services should be appraised as well as existing services and plans for services in neighboring communities. Not only the cost of building any new facility, but of operation and maintenance as well, must be considered.

Is the population rather stable, or one that is changing rapidly? It may be necessary to do some joint planning with adjacent counties or communities to include enough people to support the project. Better transportation to an existing health facility may be what is most needed. When calculating the distance to a hospital, the length of time required to get there is more important than the number of miles. Good year-round roads and ambulance service widen the area that a hospital can serve.

In sparsely settled regions, a plan has been proposed to station ambulances at outpost clinics which are under the direction of a hospital, for quick transportation of patients to hospitals. To have every family within reach of hospital and other needed health facilities is the goal. To work out plans for attainment which meet conditions in rural areas is the task.

Building an all-weather road to shorten the travel time to the nearest hospital might be more effective—and less costly—than building another small hospital. The Public Health Service through State and local health departments, and other agencies through State and county workers, are ready to help a local group work out plans to meet their local needs in relation to plans for the entire area.

3. If your community desires to build a hospital or public health center or any of the other kinds of health facilities eligible for Federal assistance, apply to your State hospital construction agency for information and advice about defining the services required. Many of the State agencies have available summary material on individual hospitals built in the State, as well as general guide materials on suggested floor plans, equipment, and staffing.

At the end of this bulletin you will find the name and address of the hospital construction agency in your State. Each community will need to employ its own architect to develop specific building plans.

4. If a building program is decided upon, a sponsoring group representative of all segments of the area to be served may be appointed. This group enlists support and raises funds. It explores possibilities of county, State, and Federal aid. Not infrequently funds from philanthropic foundations are available. The Duke Endowment, for example, gives aid in the operation of hospitals in small communities in North Carolina and South Carolina.

5. Help from professional groups can be secured in obtaining personnel for the facility. State and county medical associations, nurses' associations, public health officers, health workers in the university extension service, and others can be approached.

If a clinic is built, local health personnel can be supplemented by visiting specialists from a hospital, who can spend certain days each week at the center to care for local patients. Large hospitals, where personnel are taught and trained, sometimes help small hospitals to get the services of doctors on a full or part-time basis.

Although staffing is often a serious problem, experience shows that doctors and nurses are attracted to a new hospital. Also, nurses may be attracted to employment in a hospital close to home. In a 1954 study of hospitals in small communities, two out of every five professional nurses were local housewives who were resuming a nursing career.

6. The next step is to work out a plan that will enable people to pay for the hospital services they need. Enrollment in health insurance plans may be developed by a county cooperative health or hospital association, by a nonprofit association, such as Blue Cross, or by insurance companies using the county or community as a basis for enrollment. Some localities enroll most of the residents through employed groups and farmers' organizations.

7. Educational programs may be promoted to make people aware of health needs and goals. Good individual and family health practices begin in the home and extend into the community. Programs in schools and clubs may be planned (1) to encourage effective use of available medical services and (2) to awaken the community to the need for additional facilities.

Good health is probably the most important asset of an individual, a family, a community, and the Nation. United effort—local, State, Federal—can accomplish much in bringing health facilities and services to all our people.

N1875X

Hamilton County Public Hospital, Webster City, Iowa, is an example of the many hospitals remodeled and enlarged with the help of Hill-Burton funds. An addition of 50 beds and other improvements cost $778,217, of which Federal aid supplied $254,636.

AGENCIES ADMINISTERING THE HOSPITAL SURVEY AND CONSTRUCTION PROGRAM

ALABAMA State Department of Public Health, Montgomery
ALASKA Department of Health and Welfare, Juneau
ARIZONA State Department of Health, Phoenix
ARKANSAS State Board of Health, Little Rock
CALIFORNIA State Department of Public Health, Berkeley
COLORADO State Department of Public Health, Denver
CONNECTICUT State Department of Health, Hartford
DELAWARE State Board of Health, Dover
DISTRICT OF COLUMBIA Department of Public Health, Washington, D.C.
FLORIDA Development Commission, Tallahassee
GEORGIA Department of Public Health, Atlanta
GUAM Department of Medical Services, Agana
HAWAII Department of Health, Honolulu
IDAHO Department of Health, Boise
ILLINOIS Department of Public Health, Springfield
INDIANA State Board of Health, Indianapolis
IOWA State Department of Health, Des Moines
KANSAS State Board of Health, Topeka
KENTUCKY State Department of Health, Frankfort
LOUISIANA Department of Hospitals, Baton Rouge
MAINE Bureau of Health, Augusta
MARYLAND State Department of Health, Baltimore
MASSACHUSETTS Department of Public Health, Boston
MICHIGAN Department of Health, Lansing
MINNESOTA State Department of Health, Minneapolis
MISSISSIPPI Commission on Hospital Care, Jackson
MISSOURI Department of Public Health and Welfare, Jefferson City
MONTANA State Board of Health, Helena
NEBRASKA State Department of Health, Lincoln
NEVADA State Department of Health, Carson City
NEW HAMPSHIRE Department of Health and Welfare, Concord
NEW JERSEY State Department of Institutions and Agencies, Trenton
NEW MEXICO Department of Public Health, Santa Fe
NEW YORK State Department of Health, Albany
NORTH CAROLINA Medical Care Commission, Raleigh
NORTH DAKOTA State Department of Health, Bismarck
OHIO Department of Health, Columbus
OKLAHOMA State Department of Health, Oklahoma City
OREGON State Board of Health, Portland
PENNSYLVANIA State Department of Public Welfare, Harrisburg
PUERTO RICO Department of Health, San Juan
RHODE ISLAND Department of Health, Providence
SOUTH CAROLINA State Board of Health, Columbia
SOUTH DAKOTA State Department of Health, Pierre
TENNESSEE Department of Public Health, Nashville
TEXAS State Department of Health, Austin
UTAH State Department of Health, Salt Lake City
VERMONT Department of Health, Burlington
VIRGIN ISLANDS Department of Health, St. Thomas
VIRGINIA State Department of Health, Richmond
WASHINGTON State Department of Health, Olympia
WEST VIRGINIA State Department of Health, Charleston
WISCONSIN State Board of Health, Madison
WYOMING State Department of Public Health, Cheyenne

Cover Picture

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Lawrence County Hospital, Lawrenceville, Ill., is typical of many hospitals built with Federal aid. The total cost was $971,000; the Federal share was $323,700. This is a 50-bed general hospital and a public health center. Joint housing of hospital and public health facilities is one way to increase efficiency and to facilitate the coordination of preventive and curative medicine, resulting in better health services for the individual and community. The entrance to the health center may be seen at the left of the main hospital entrance.